MINUTES

JUNE 21, 2011

INTERAGENCY FORENSIC SERVICES COMMITTEE
MARYLAND ADVISORY COUNCIL/PLANNING COUNSEL

Attending Members: Larry Fitch (Co-Chair), Honorable George Lipman (Co-Chair), Marian Bland, Karen Yoke, Sarah Rhine, Robin Weagley, Neil Woodson, Lynn Edwards

Members Absent: Bonnie Cosgrove, M. Sue Diehl, Lois Fisher, Jim Holwager, Julia Jerscheid, Phyllis McCann, Leslie McMillan, Patricia Schupple, Penny Scrivens, Susan Steinberg, Donna Wells, Beverly Wise

Guests: JoAnne Dudeck, Jane Plapinger

Handouts:
· Johns Hopkins Bayview Community Psychiatry Program information

Judge Lipman handed out information about the services available in the Johns Hopkins Bayview Community Psychiatry Program as a reference and model for wrap around psychiatric rehabilitation services.

Presentation

Jane Plapinger, President and CEO of Baltimore Mental Health System, and previously Assistant Commissioner, Bureau of Planning, Evaluation and Quality Improvement for New York City Department of Health and Mental Hygiene, discussed the elements of the New York City Assisted Outpatient Treatment (AOT) voluntary outpatient commitment to community-based mental health services.

1. Intensive Care Coordination
2. Service Capacity
3. System accountability
4. Eligibility criteria
5. Referral flexibility
6. Commitment to the program

The local regions were responsible for providing these services. The state required the person to be seen once a week and reports to be provided on the person's history of engagement. Each person received services from either case management or from an assertive community treatment team. Service capacity included increased access to treatment, housing employment programs.

There were also different layers of accountability in the system. Each bureau was required to conduct regular audits for each of the AOT's. For people who failed to remain engaged in treatment, audits were conducted by the program audit office. The state AOT Program also did audits. Reports were required weekly to ensure providers were making connections with people and following up. It was "not acceptable to lose track of people". There were also time frames for developing service plans.

The eligibility threshold was lower, and there was flexibility on who can refer the person. This program had a lot of commitment from the state and from the participants. A significant amount of local funding and later state funding were committed to this initiative (About 120 million in services alone).

Discussion

The committee compared this NYC effort to services in Maryland. One major difference is that the AOT legislation, "Kendra's Law", came about as a response to a tragedy and came with funding. This program was targeted for people who have a mental illness and are chronically disengaged from available services/treatment. The NY project did not include those on conditional release, or those on probation which is the focus in Maryland. However, NY's system of accountability may be an element Maryland should look at. Although deficits in care coordination and service capacity have been established barriers to recovery outcomes for people with psychiatric disabilities, some members offered that the system accountability element may be something to look at in Maryland.

Jane mentioned that she has noticed that some community providers are less likely to admit the most severely disabled or severely disengaged into their programs. For those programs that do accept the severely disabled or disengaged, there is no outreach provided when people do not attend appointments. This is where more system accountability would assist.

It was mentioned that in MD it is the responsibility of those on conditional release and probation to meet the conditions of their release. This is an area where some provider accountability would be helpful.

Jane also emphasized how important the commitment of staff is. Although the energy and momentum involved in putting together the NYC project was great, it was mostly due to having the highest officials support the initiative; there was training, and there were resources. The committee agreed that care coordination (case coordination/case management) and service capacity is critical in all successful outcomes. More intensive care coordination for individuals with mental illness would be greatly helpful in Maryland. More outreach and follow-up is key. For service capacity, one focus in this meeting was housing. NYC has increased housing through many years of joint efforts in their housing administrations, where Maryland has not.

It was agreed that a workgroup be established, including staff from BMHS, the state housing office (DHCD), Tomi Heirs from the Mayor's office, and other key members. The workgroup would explore how New York City's initiative might be replicated in Baltimore and possibly other areas of Maryland.

Karen Yoke mentioned ADAA received an access to recovery grant for those leaving residential programs and prisons which is line with Jane's presentation.

The next meeting will be held in September. In the interim Larry will establish the workgroup noted above.

Meeting adjourned at 4:30 p.m

Minutes submitted by Lynn Edwards 6/28/11

*An update to the minutes is that a new workgroup within this committee will not be established because instead, another new workgroup will look at outpatient commitment issues for Maryland. Jane Plapinger will chair a subcommittee in that workgroup titled:

Balancing Public Health and Individual Liberties: Exploring New Options in Outpatient Treatment
University of Maryland Schools of Law, Medicine, and Social Work